JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency

Department of Health Care Services

Local Educational Agency (LEA)
Medi-Cal Provider Enrollment Information Sheet
2017-2018 Fiscal Year

EDMUND G. BROWN JR.
GOVERNOR

Date: _____

Official LEA Name: _____

Doing Business As: _____
(If different from the official LEA name)

Check all that apply ☐ New LEA (Complete PPA) ☐ Charter School ☐ Billing Consortium (Complete Consortium Billing Page) ☐ Update LEA Name (Complete PPA)

LEA Address

☐ Update Address

LEA Administrative Office Address: _____
(Not a Post Office Box)

Payment/Mailing Address: _____
(If updating Payment/Mailing Address, submit Form 6209 to Provider Enrollment Division)

LEA Contact Information

☐ Update Contact

Primary Contact: _____ Title: _____

Phone Number: _____ Email: _____

Secondary Contact: _____ Email: _____

LEA Vendor/Billing Agent Information

☐ Update Vendor Information

Vendor/Billing Agent: _____ Phone: _____

Contact Person: _____ Email: _____

LEA Identification Codes

California School Directory (CDS) Code: _____

National Provider Identification (NPI) Number: _____

LEA Federal Employer Identification Number (EIN): _____

LEA Authorization

Signature of Authorized Representative: _____

Name of Authorized Representative: _____

Title of Authorized Representative: _____

DHCS USE ONLY
Effective Date:
Date Added:

State of California—Health and Human Services Agency

Department of Health Care Services

Local Educational Agency (LEA)

Consortium Billing

2017-2018 Fiscal Year

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Enter the LEA name, CDS Code, and District for each LEA billing under the NPI number provided. Print additional pages if needed.
Do not include individual schools within the district.

The following LEAs are part of: _____ consortium and bill under
(Type LEA Name)

NPI #: _____
(Type NPI Number)

	LEA Name	**CDS Code** (enter all 14 digits)	**District Name** (if different than LEA Name)	**Charter** (Yes/No)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				

State of California—Health and Human Services Agency

Department of Health Care Services

Local Educational Agency (LEA)

CERTIFICATION OF STATE MATCHING FUNDS FOR LEA SERVICES

(LEA Program Annual Report: ATTACHMENT 1)

JENNIFER KENT
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National Provider Identification Number

In accordance with the California Code of Regulations (22 CCR 51270), Local Educational Agencies (LEAs) are required to certify a specific amount available in non-federal matching fund to participate in the LEA Medi-Cal Billing Option Program.

_____
(LEA Name)

has budgeted $_____ for the fiscal year beginning **July 1, 2017 and ending June 30, 2018** to cover wages, benefits, and administrative costs of employees who provide health services and activities covered by the LEA Medi-Cal Billing Option Program.

This also certifies that the funds budgeted for the fiscal year are non-federal, certified public LEA Medi-Cal Billing Option Program eligible funds to finance LEA Program activities. These funds will be matched through the LEA Program claiming process to receive an equal amount of federal Medicaid funds. Once the LEA named above has received reimbursement from Medicaid in the amount set forth above, billings from this LEA shall cease until such time as it is re-certified that additional matching funds are available.

The undersigned is authorized to enter into this agreement on behalf of named School District/LEA; therefore, the School District/LEA is bound to the terms and conditions contained herein.

_____ Date: _____
Signature of Authorized Representative

_____
Name of the Authorized Representative

_____
Title of the Authorized Representative

ANNUAL REPORT FINANCIAL STATEMENT DATA
FOR PRIOR YEAR CLAIMING
(LEA Program Annual Report: ATTACHMENT 1A)
July 1, 2016 – June 30, 2017
(LEA Medi-Cal Billing Option Revenue Only)

JENNIFER KENT
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National Provider Identification Number

The Local Educational Agency (LEA):

_____
(LEA Name)

Total LEA dollars received during fiscal year 2016-2017 (a) _____
(based on the LEA's financial records)

Unspent LEA funds from previous fiscal year(s) (b) _____

Total Revenue (lines a + b) (c) $ 0.00

California Education Code Section 8804(g) outlines the appropriate reinvestment of LEA funds. Using the check-boxes below, please indicate reinvestment expenditures made by your LEA during fiscal year 2016-2017, regardless of year the revenue was received (check all that apply):

- ☐ Health care, including:
  (A) Immunizations
  (B) Vision and hearing testing and services
  (C) Dental services
  (D) Physical examinations, diagnostic, and referral services
  (E) Prenatal care
- ☐ Mental health services, including primary prevention, crisis intervention, assessments, and referrals, and training for teachers in the detection of mental health problems.
- ☐ Substance abuse prevention and treatment services.
- ☐ Family support and parenting education, including child abuse prevention and school-age parenting programs.
- ☐ Academic support services, including tutoring, mentoring, employment, and community service internships, and in-service training for teachers and administrators.
- ☐ Counseling, including family counseling and suicide prevention.
- ☐ Services and counseling for children who experience violence in their communities.
- ☐ Nutrition services.
- ☐ Youth development services, including tutoring, mentoring, recreation, career development, and job placement.
- ☐ Case management services.
- ☐ Provision of onsite Medi-Cal eligibility workers.
- ☐ Other: _____

_____

STATEMENT OF COMMITMENT TO REINVEST
FOR CURRENT YEAR CLAIMING
(LEA Program Annual Report: ATTACHMENT 2)

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

National Provider Identification Number

The Local Educational Agency (LEA):

_____
(LEA Name)

hereby certifies that:

1) A local collaborative has been formed;
2) The local collaborative will include among its responsibilities the decision making process regarding the reinvestment of funds made available through participation in the LEA Medi-Cal Billing Option Program, as outlined in Article II, Section 10 of the Provider Participation Agreement; and
3) The reinvestment of funds will remain within the school-linked support services identified in Article II, Sections 8, 9 and 10 of the Provider Participation Agreement.

As specified in the LEA Medi-Cal Billing Option Program Provider Participation Agreement, LEAs participating in the Medi-Cal Billing Option Program must submit an LEA Annual Report describing their collaborative, service priorities, and reinvestment expenditures each Fiscal Year (FY). Please describe the role of your LEA's collaborative by answering how reinvestment decisions are made, and the planned frequency of meetings.

1. Description of LEA Medi-Cal Collaborative decision-making process and frequency of meetings:
   (The LEA collaborative is required to meet a minimum of twice per year)

   a. How are LEA Medi-Cal Collaborative decisions made? (Check one)

   ☐ Consensus ☐ Majority Vote ☐ Other

   b. What is the frequency of LEA Medi-Cal Collaborative meetings? (Check one)

   ☐ Monthly ☐ Every Other Month
   ☐ Quarterly ☐ Every Six Months
   ☐ Other - Explain: _____

2. Anticipated service funding priorities of the LEA Medi-Cal Collaborative for FY 2017-18.
   Please describe plans for the potential use of Medi-Cal reimbursement that your LEA has not received yet.

   List Program Service Items:

STATEMENT OF COMMITMENT TO REINVEST

(LEA Program Annual Report: ATTACHMENT 2A)

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GOVERNOR

National Provider Identification Number

The Local Educational Agency (LEA):

_____
(LEA Name)

Signatures of the local collaborative partners below indicate an understanding of and commitment to the statement of commitment to reinvest outlined in Attachment 2.

The interagency collaborative shall consist of at least three individuals with varying interest in the reinvestment of funds for the LEA Program. The collaborative membership shall involve representatives from the schools, public agencies serving children and families, parent groups of pupils of qualifying schools, community representatives and private partners.

LEA INTERAGENCY COLLABORATIVE PARTNERS

Date: _____

Name/Title of Collaborative Partner: _____

Organization of Collaborative Partner: _____

Signature of Collaborative Partner: _____

Date: _____

Name/Title of Collaborative Partner: _____

Organization of Collaborative Partner: _____

Signature of Collaborative Partner: _____

Date: _____

Name/Title of Collaborative Partner: _____

Organization of Collaborative Partner: _____

Signature of Collaborative Partner: _____

Date: ____________________

Name/Title of Collaborative Partner: ____

Organization of Collaborative Partner: ____

Signature of Collaborative Partner: ____

Date: ____________________

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Name/Title of Collaborative Partner: ____

Organization of Collaborative Partner: ____

Signature of Collaborative Partner: ____

Date: ____________________

Name/Title of Collaborative Partner: ____

Organization of Collaborative Partner: ____

Signature of Collaborative Partner: ____

Date: ____________________

Name/Title of Collaborative Partner: ____

Organization of Collaborative Partner: ____

Signature of Collaborative Partner: ____